Baby Watch
Early Intervention Program
Birth To Three Development

Health Hearing and Vision Assessment

Health Assessment

Child Name:_____

Parent Name(s):_____ Phone Number:_____

DOB:_____ Age:_____months Gestation:_____ weeks Male___ Female___

Health Assessment Date:_____ By:_____RN

Nurse Review of Records Date:_____ By:_____RN

Primary Care Physician:_____ Phone Number:_____

Other medical professionals involved in child's care:_____

_____

Diagnoses:_____Date:_____

Did mother receive routine prenatal care? ☐ Yes ☐ No

Was there prenatal exposure to smoking, alcohol, medications, or toxic substances? List:_____

At birth the child's health was: ☐ Stable ☐ Unstable List Issues:_____

If Premature: ☐ IVH ☐ ECMO ☐ ROP ☐ Ventilator # of days_____ ☐ Oxygen # of days_____

History of significant illnesses, injuries, surgeries, seizures, TBI:_____

_____

☐ No hospitalizations (After normal newborn discharge)

☐ Hospitalization history:_____

☐ No current medications ☐ Current medications/supplements:_____

Parent's concerns about child's health:_____

Is there a family history of learning problems, developmental concerns, mental health concerns? ☐ No ☐ Yes

Does either parent have a family history of Autism? ☐ No ☐ Yes

Have you or anyone who knows your child been concerned about Autism? ☐ No ☐ Yes

Nutrition

___NG/NJ/GT feeds
___Bottle/breast feeds ___Times a day
___Cereal ___Fruit ___Veggies ___Meat
___Table foods ___Textured foods
___Finger feeds ___Spoon feeds
___Drinks from cup ___Sippy cup
___Vitamin D if breast fed

Are there concerns about child's weight gain?_____
Does child have: ___Reflux ___Special diets
___Other concerns with feeding/nutrition:_____
_____
Does child have trouble chewing/swallowing? What food types?_____
_____
___Receives WIC Services

Growth

Weight_____ _____%
Length/Height_____ _____%
OFC_____ _____%
Corrected % ☐ Yes ☐ No
Birth Weight_____ Length_____

Medical Home

Gets regular well child checks? ☐ No ☐ Yes
Last well child check:_____
Developmental Screening? ☐ No ☐ Yes
Results:_____

Immunizations Status

Determined at visit:
___Current for age (or corrected age)
___Not current but has plan to get current
___Using modified schedule
___Declines immunizations

Temperament	Sleep	Elimination
___Generally happy ___Irritable ___Calms easily ___Hard to calm ___Hyperactive ___Colicky Interactive ☐ Yes ☐ No	___Sleeps through night ___Naps in day ___Regular sleep schedule ___Poor sleeper ___Times wakes at night ___Snores ___Mouth breather Sleep location: ___Crib ___Parents Sleep Position ___Back ___Stomach	Stools: ___Liquid ___Loose ___Pasty ___Formed ___Hard ____Per day Number of wet diapers a day:_____ ___Normal male/female genitalia
Respiratory	**Cardiovascular**	**Musculoskeletal**
___On O2 NC ___Trach ___Respiration unlabored ___Breath sounds clear ___Wheezes ___Cough ___Rales ___Retractions	___CCHD Screening ☐ Pass ☐ Fail ___Apnea/Bradycardia ___Heart problems Type:_____ Normal heart sounds ☐ Yes ☐ No Describe:_____	___Normal gait ___Hypotonic ___Hypertonic ___Strength equal bilaterally/upper/lower ___ROM ___Normal for age ___Neck Tightness
Mouth	**Skin**	**Allergies**
___Normal appearance ___Excessive drooling ___Teething ___Mucous membranes pink & moist ___Has child seen dentist if over age one? ___Dental caries Do you brush child's teeth? ☐ Yes ☐ No	___Normal ___Pale ___Jaundice ___Intact, dry, good turgor ___Rash ___Excoriation ___Edema ___Eczema ___Bruises ___Birth marks Describe:_____	___No known allergies ___Allergies List:_____ _____ ___Allergies to foods List:_____ _____

Health Status Summary (check all that apply):

☐ Child appears to be in good general health

☐ Child has some health concerns

☐ Health concerns are being addressed with medical professionals

☐ There are some concerns NOT currently being addressed

Hearing Assessment

Hearing Assessment Date:_____ By:_____

Newborn hearing screening: Pass___ Fail___ Any follow-up?_____

If failed Newborn hearing screen, child tested for CMV? ☐ Positive ☐ Negative ☐ Not completed

History of ear infections? ☐ Yes ☐ No How many?_____

History of ear tubes? ☐ Yes ☐ No Date:_____

Concerns about child's hearing? ☐ Yes ☐ No List:_____

Family history of childhood hearing loss? ☐ Yes ☐ No List:_____

Facial features: ☐ Ear tags or pits ☐ low, lopsided atypical ears ☐ cleft lip or palate ☐ irregularly spaced eyes or ears

Child's Hearing Summary (Check all boxes that apply): ☐ Pass ☐ Refer ☐ Refer to PIP-DHH ☐ Inconclusive

Assessment:	Date:	Pass/Fail: Right ear: Left ear:
☐ Audiological report		
☐ OAE		
☐ Tympanogram		

Vision Assessment

Vision Assessment Date:_____ By:_____

Is there a family history of vision problems before the age of 5 years? ☐ No ☐ Yes_____

Are there concerns about your child's vision? ☐ No ☐ Yes_____

Does child resist any efforts to occlude or cover one eye more than the other? ☐ No ☐ Yes

Appearance of eyes: (Mark all that apply, indicate R or L or B)

____Tracking ____Fixates

____Cloudy milky appearance ____Keyhole pupil

____Pupil does NOT respond to light ____Difference between eyes (size, shape)

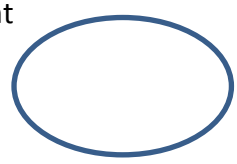
____Excessive sensitivity to room light ____Excessive tearing

____Droopy eyelid ____Jerky eye movement

Is Misalignment Observed? ☐ No ☐ Yes Do not test for misalignment under three months adjusted age.

If misalignment is noticeable draw where eyes usually rest. ☐ With glasses ☐ Without glasses

Right



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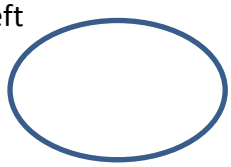
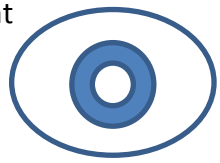


Where is light reflected in both eyes? Corneal light reflection,place a dot in the pupils below where the reflection is observed.

Right



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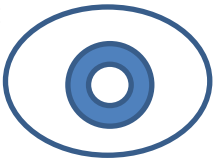

Child's Vision Summary (Check all that apply): ☐ Pass ☐ Refer ☐ Refer to PIP-BVI ☐ Inconclusive

☐ Ophthalmological report ☐ USDB report ☐ Other_____

Eye Care Specialist:_____ Date:_____

OBSERVED EYE RESPONSES/VISUAL BEHAVIORS: (check each item observed)

INSTRUCTIONS: Begin testing at approximate developmental age.

Complete at least 3 consecutive sections, identifying both a baseline and ceiling according to assessment protocol.

Yes No **BIRTH:**
- ☐ ☐ Responds to movement or light with a blink reflex
- ☐ ☐ Pupil responds to light on/off
- ☐ ☐ Makes momentary eye contact

Comments _____

Yes No **1 MONTH:**
- ☐ ☐ Turns head & eyes to light source
- ☐ ☐ Regards face
- ☐ ☐ Follows movement horizontally, either side of midline

Comments _____

Yes No **2 MONTHS:**
- ☐ ☐ Turns head to objects/lights on either side
- ☐ ☐ Stares at objects or people
- ☐ ☐ Social smile in response to a smile from another

Comments _____

Yes No **3 MONTHS:**
- ☐ ☐ Follows object (tracks) 180 degrees
- ☐ ☐ Regards own hands
- ☐ ☐ Follows movement of people & objects

Comments _____

Yes No **4 MONTHS:**
- ☐ ☐ Glances from one object to another
- ☐ ☐ Uses vision to reach towards 1" object at 12"
- ☐ ☐ Looks at 4" – 6" object at 3 feet

Comments _____

Yes No **BY 6 MONTHS:**
- ☐ ☐ Watches rolling tennis ball at 10 feet
- ☐ ☐ Uses vision to reach directly to object
  - ☐ Over reaches ☐ Under reaches
- ☐ ☐ Uses eyes together

Comments _____

Yes No **BY 9 MONTHS:**
- ☐ ☐ Looks for fallen toy
- ☐ ☐ Eyes converge on moving toy to within 4" of face
- ☐ ☐ Watches activity of adults 15 – 20 feet

Comments _____

Yes No **BY 12 MONTHS:**
- ☐ ☐ Recognizes familiar object (bottle, toy) at 8-10'
- ☐ ☐ Looks at pictures in a book
- ☐ ☐ Looks at/picks up small object (raisin, cereal)

Comments _____

Yes No **BY 18 MONTHS:**
- ☐ ☐ Uses vision to tower 3, 1 inch cubes
- ☐ ☐ Looks at/points to pictures named
- ☐ ☐ Attends to 2" – 3" stationary object at 10 feet

Comments _____

Yes No **BY 24 MONTHS:**
- ☐ ☐ Imitates facial and hand movements
- ☐ ☐ Walks confidently in unfamiliar or varying surfaces
- ☐ ☐ Visually locates identical objects (begins matching)

Comments _____

Yes No **BY 30 to 36 MONTHS:**
- ☐ ☐ Recognizes self in photo/mirror
- ☐ ☐ Imitates actions (finger plays, on, under, behind)

Comments _____

NOTES/CONCERNS: _____